

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS235S	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2009
NAME OF PROVIDER OR SUPPLIER NORTH LAS VEGAS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3215 E. CHEYENNE AVE. NORTH LAS VEGAS, NV 89030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on August 10, 2009, in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing.</p> <p>Complaint #NV00022052 was substantiated with no deficiencies cited.</p> <p>Complaint #NV00022011 was substantiated with and unrelated deficiency cited. See Tag Z 359.</p> <p>A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.</p> <p>Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p>	Z 000		
Z359 SS=A	<p>NAC449.74515 Physicians</p> <p>5. At each visit to a patient required by subsection 4:</p> <p>(a) The patient's plan of care must be reviewed, including, without limitation, the medications and treatments prescribed for the patient;</p> <p>(b) Progress notes of the visit must be prepared, signed and dated; and</p> <p>(c) Any orders for the treatment of the patient</p>	Z359		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Z359	Continued From page 1 must be signed and dated. This Regulation is not met as evidenced by: Based on record review and interview the facility failed to ensure that the physician signed verbal orders in accordance with facility policy for 1 of 3 residents. (Resident #1) Severity 1 Scope 1	Z359		

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